Health Professions Trainee (HPT) Registration
WJB Dorn VA Medical Center

Please print, complete and sign this document before returning to Education Service or faculty member. All information is for official use only and will be kept confidential.

Last Name		**First Name**			
Email		**Date of Birth**		**Sex**	
Street Address					
City		**State**		**Zip**	
VA Rotation Location (Ward or Department)		**VA Location Ext Number:**			
Rotation Start Date		**Rotation End Date**			
Pay/Salary/Stipend	☐ Yes, paid by school ☐ Yes, paid by VA ☐ No				
Educational Institution					
Discipline (Major of Study)					
Degree Level (i.e. Associate, Bachelors)		**Anticipated Graduation Date**			

(**Initial** in the space provided.)

_____ I understand that I am required to wear my VA ID Badge whenever I am on duty at the VA.

_____ I understand that I am **STRICTLY PROHIBITED** from disclosing my computer access codes to ANYONE, including my family, friends, fellow workers, supervisor(s), and subordinates, for ANY reason.

_____ I understand that I must go to the Education Service Line to complete out-processing requirements at the end of my training at the VA. I understand I must surrender my VA ID Badge and parking decal/card. I understand also that my computer access will be withdrawn at the end of my training at the VA.

_____ HIPAA Minimum Necessary Standard for Protected Health Information: I understand I am assigned to the Direct Patient Care Functional Category which allows me access to the entire medical record for treatment purposes.

_____ _____

Signature Date

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Reviewed/Updated 7/30/2013